

step is repeated on the opposite side. The mucosa directly in the median line is dissected backward for about one-half inch. In recent tears this dissection is not necessary, while cases presenting a large rectocele may require more extensive denudation and resection of considerable mucosa. Allis snaps are now introduced into the two lateral openings and grasp a thick bundle of the levator ani muscle. These muscles are then drawn into the field and sutured in the median line with No. 2 chromic catgut. Usually two or three sutures are sufficient. This forms the basis of the new pelvic floor. An Allis snap now grasps the mid point of the cut edge of vaginal mucosa, and three or four sutures of No. 1 plain catgut approximate the vaginal mucosa and underlying tissue.

Number 2 chromic catgut on a medium sized cutting needle is used for skin suturing. These needles pass through the skin, catch the fascia underneath, and are brought out through the tissues of the opposite side in the reverse order. From four to six skin sutures are required: the lower ones being tightly brought together, while those nearer the vagina have less tension placed upon them, since the tissues in this region are more apt to be cut.

The vaginal pack is removed, the iodine is sponged off with alcohol, sterile vaseline is applied to the groins, and a vulva pad applied. The knees are hobbled so as to allow them to separate about 12 inches. If the knees are hobbled tightly together, drainage of lochia is prevented, with a subsequent rise in temperature and possible infection of stitches.

The most important point in the after-care of these cases is "letting the perineum alone." The stitches are washed once a day with a non-alcoholic solution of green soap, preferably after the morning bowel movement. After urination the stitches are dried with gauze sponges. No external douching is allowed. Heroin, gr. 1/24 to 1/12 is given every four hours for twenty-four hours, beginning when the patient returns from the surgery; during this period the baby does not take the breast. After twenty-four hours one dose of heroin is given each evening for two or three nights. The pain after complete repair is severe, and opiates should be given freely to obtain the best results. A laxative is ordered 36 hours after operation, after which the patient receives the usual post-partum care.

The following averages have been computed on a series of repairs, half of which were the secondary type of operation, while the remaining half were the intermediate type. The figures seem to prove my contention that the results following the intermediate type of operation are not only as good as those following the secondary type, but better, probably because a majority of secondary repairs are associated with other operative procedures resulting from old lacerations.

## TABULATED RESULTS IN ONE HUNDRED PERINEORRHAPHIES

INTERMEDIATE		SECONDARY	
27.....	Average age .....	30	
31.....	Primiparas .....	12	
19.....	Multiparas .....	38	
3.....	Day after delivery.....		
18 min...	Time of operation.....	24 min.	
1.....	Cervix only .....	0	
37.....	Cervix and perineum.....	33	38
12	Cervix, perineum & post. colporr.	3	with
0.....	Perineum only .....	8	laps
DELIVERY:			
42.....	Normal .....	43	
5.....	Forceps .....	7	
2.....	G Version .....	0	
2.....	Breech .....	0	
COMPLICATIONS:			
2.....	Episiotomy .....		
1.....	Pneumonia .....	0	
2.....	Nephritis .....	0	
0.....	Mastitis .....	1	
0.....	Bartholinitis .....	1	
0.....	Cystitis .....	6	
RESULTS:			
32.....	Excellent .....	23	
14.....	Good .....	19	
2.....	Fair .....	8	
UTERUS:			
38.....	Normal position .....	42	
10.....	Retroverted .....	4	
2.....	Not examined .....	4	
ANAESTHETIC:			
2.....	Gas .....	0	
30.....	Ether .....	27	
18.....	Gas-Ether .....	3	
0.....	Ether-Scopolamine .....	20	

## REPORT OF TWO CASES OF ETHMOIDAL MALIGNANCY.\*

By P. A. JORDAN, M. D., San Jose, Cal.

My reasons for presenting the history of the following two cases are two-fold, i. e., the rarity of malignancy in nasal diseases in my practice of sixteen years, and secondly, urging the early use of radium in treatment, which lends a hope of recovery.

I have seen altogether but four cases of intranasal malignancy, three of whom died rather speedily after diagnosis was established. The fourth one is undergoing rapid decline.

### Case 1.

P. E., female, age 55. History rhinitis chronic. Feb. 19, 1917—Turbinotomies by Dr. G. T. Jordan, Chicago.

Apr., 1917—Came under my observation for acute otitis media and acute mastoiditis left. Recovery without operation other than paracentesis.

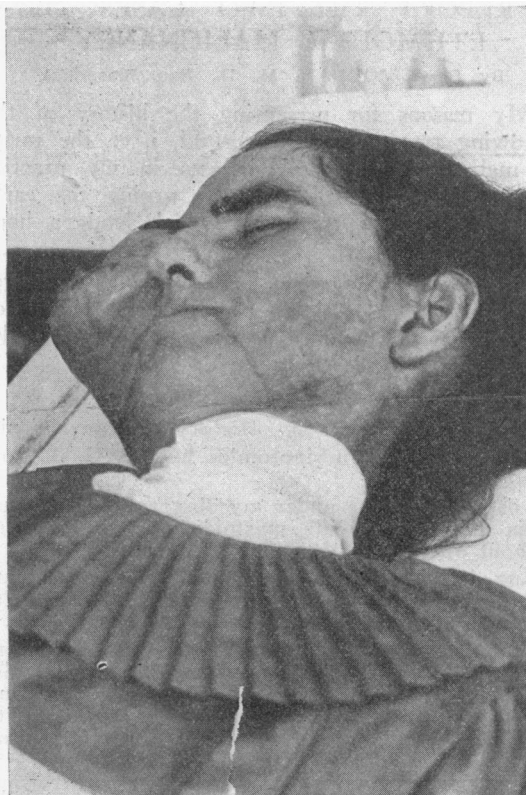
Aug. 19, 1918—Removal portion inferior turbinate and drainage much pus from enlarged bulla. Malignancy not suspected.

Sept. 19, 1918, or one month later, removed granular, tumorous, bleeding mass, including much degenerated inferior turb. right. Antral wall absent, much granular tissue removed from antral cavity and ethmoidal region. Specimen sent Dr. Wm. Ophuls, who returned diagnosis of carcinoma.

\* Read before the Forty-eighth Annual Meeting of the Medical Society of the State of California, Santa Barbara, April 1919.



Case 2. Front View—Sarcoma.



Case 2. Side View—Sarcoma.

Sept. 21, or two days later, after consultation with Dr. Sewell, placed patient under care of Dr. Boardman for X-ray treatment, who through his assistant gave grave prognosis for recovery. About three weeks later was given radium treatment in Chicago. Again in Jan., 1919, or three months later, radium was used. Disease so far has not returned. Patient in declining health at present, but not seen by me for six months.

#### Case 2.

Mrs. L. B., female, age 36. First came under my observation Dec. 17, 1917, exhibiting numerous polypi right middle turbinate region; also long prominent septal ledge right.

Operation three days later—sub-mucous resection ledge, middle turbinectomy and ethmoidectomy.

One year later patient returned, complaining of nasal hemorrhage and pain in region of right ethmoid, and exhibiting exophthalmos right eye. Inspection showed ethmoidal region to be filled with new growth. Malignancy was suspected and feared. Wassermann was immediately ordered, which was double positive. Hope was entertained that growth might be gummata. Anti-luetic treatment was not curative.

Dec. 28, 1918—Exenterated ethmoidal region. Specimen sent to Dr. Wm. Ophuls, and also to Columbia Hospital, pathological department, San Jose. Both reported sarcoma. Radiograms showed new growth, filling of ethmoidal region, lower half of orbit and right antrum.

X-ray and radium treatment were not tried, as patient presented self at late stage and family conditions made same scarcely possible.

Jan. 14, 1919—Seventeen days after extenteration of ethmoid, patient presented very marked exophthalmos right and much pain. Vision right eye 6/200. Operation: Enucleation, extenteration orbit, ethmoidal region, antrum Highmore. Bony partitions were largely absent. Rapid return of growth until at death of patient Mar. 16, or two months after enucleation the growth had attained the hideous size shown in the accompanying photos, or an external right-sided growth 16 cm. by 12 cm. by 7 1/2 cm.

#### ACHYLIA GASTRICA—A NOTE REGARDING TREATMENT.

By ELBRIDGE J. BEST, M. D., San Francisco.

The term achylia gastrica was applied by Einhorn<sup>1</sup> in 1888 to a certain number of cases that revealed, on gastric analysis, an absence of free hydrochloric acid, and gastric ferments with a total acidity of about 10. Because these cases showed no other pathology, the gastric condition was considered a separate entity due to a neurosis.

During the succeeding years, the diagnosis has been made many times on entirely insufficient evidence, such as the mere absence of HCl in one sample of stomach contents, and an incomplete physical examination.

Since the advent and widely adopted use of the fractional stomach analysis, as introduced by Reh-fuss,<sup>2</sup> and further described by the author,<sup>3</sup> studies of these so-called achylia have revealed very interesting information. It has definitely proved the presence of hydrochloric acid in certain phases of digestion while being absent in others. As emphasized by Reh-fuss<sup>4</sup> this has diminished the number of true achylia, as far as the gastric secretion is concerned, to a very small per cent.

Also, with a more careful physical examination and study of the patient we find this picture of achylia, as revealed by the stomach tube, appearing